# Exhibit 13

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page 1 of 10

# Application for Life Insurance Issued by American National Insurance Company One Moody Plaza, Galveston, TX 77550-7947

45937e11



1. PRIMARY P	ROPOSE	) INSURED				<del></del>	A P P
Last name Sh-en	lock	First name	olive MI	b. Birthr	olace: City	State	Country USA
Date of birth: Month/p PII			e. Height	i. Welght	Angusta g, Social Secur	itv/Tax ID num	her
Gender ☐ Male ☐ Have you ever used to	bbacco or nic	I. Marital status:	Married ☐ Separate	d □ Strigle □	—.  —	<i>-3₽</i> orced	02
was asouth Manifellat	icludes cigar ear I	ettes, cigars, pipes, ci	I Married ☐ Separate newlng tobacco, nicotine	patches or other p	roducts containing r	nicotine. If "Yes	, when was tobacco or nice
LL Mm	umber/Stree						
ears at this residence	17	PII	n. Annual Inco	THE NO	et worth	<i>یے جے</i> ا	ZIP 29849
Type of business Ca.	pet +	Vingl	Employer name	Sey-12		p. Busines	ss telephone
Occupation/Job title Salland		Job duties (Be spe	ochic.) Salum	as/mana	eyer	—,, <del>,</del> ,	<u>439 - 8843</u> nployment: Month/Year
	more			<del></del>	Augusti	-   <u></u>	ZIP 860
J.S. Citizen: DZ Yes ADDITIONAL	□ No If N	o, type of Visa			Iration Date	_ >,<	24 865
ast name	TAULUS						
ate of birth: Month/D	au/Vogr	First name	M,I.	b, Birthpl 	ace: City	State	Country
ender 🗆 Male 🗖		d. Age last birthday	e. Height f.	Welght	g. Social Securit	y/Tax ID numb	
	mber/Street			atches of other pro City	oducts coAtaining nid	coline. If "Yes," State	when was tobacco or nico
ears at this residence	m. Persons	l telephone	n Annual Incom		worth	<u> </u>	
ype of business	Employer na	ime	p. Business tele	\$_ pho <b>n</b> e	q. Relations	hlp to primary	proposed Insured
ccupation/Job title		Job dutlesque spec		· · · · · · · · · · · · · · · · · · ·	l		ployment: Month/Year
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] Male  □ Femate  ↓ alling address: Numbe			e. Age last birthday f, s	<u> </u>	OD number	g, I 	f Trust, date created
ontingent owner (If any	<u>.                                    </u>	First name	<del></del>	XIIy 	<u> </u>	State	ZIP
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ROPOSED FO		Address:	Number/Street i	noulleation	of past due	premiums);		
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ent options: L. Yes	B ∐ No ∰	Yes, complete and subm	ilt the state appropi	riate form fo	r Additional	Beneficiary	Pana I	
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	at the same addres  Y FOR PRIVIA  First name	at the same address as the proporty FOR PRIWARY PROPO  First name M.I.  For Addition Proportions:  FOR MATION  If your ber of years if Term!  FOR MATION  If your ber of years if Term!  For acceptable risks on a nonrate mium. Change face amount.  In an elected?  Fremlum reduction In an elected Universal Life and Variable Elect one In no option is selected fremlums (Alfocation must be detected fremlums (Alfocation must be detected).  For acceptable risks on a nonrate mium. Change face amount.  Indexed Universal Life and Variable Elect one In no option In selected.  Fremlums (Alfocation must be detected).  For acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium. Change face amount.  In acceptable risks on a nonrate mium.  In acceptable risks on a nonrate	First name    All   Relationship to primary proposed insured	at the same address as the proposed insured?	at the same address as the proposed Insured?	at the same address as the proposed insured?	At the same address as the proposed insured?	At the same address as the proposed insured?    YFOR PRIMARY PROPOSED INSURED    (Interest parameters)  First name   M.I. Relationship to primary   proposed Insured   M.J. Relationship to additional   Prist name   M.J. Relationship to additional   Pate of Birth:   Gender: Soc. Sec./Tax ID#   Date of trust:   Mo./Day/Yr.  W.F. P.J. S. M. No   (if "Yes," complete and submit the state appropriate form for Additional Beneficiary Page.)  YFOR ADDITIONAL PROPOSED INSURED   M.J. Relationship to additional   Date of Birth:   Gender: Soc. Sec./Tax ID#   Date of trust:   Mo./Day/Yr,   M/F   M/F   Date of trust:   Mo./Day/Yr,   M/F   Date of trust:   Mo./Day/Yr,

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Page 3 of 10		, <u> </u>								
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9896 4 of 10	AMERICAL			45937e11
13. FAMILY PHYSICIAN, SPECIALIST,	NATIONAL DR. CLUNIO			43937611
a. Family physician, specialist or clinic of proposed ins	TO GE IVIE			
Provider name	Date last visited			
		Reason for visit		HMO patient iD number
Address: Number/Street	City	) <del></del>		
	15 1 40	'State ZIP	Provider tele	ephone number
b. Family physician, specialist or clinic of additional pro	posed insured:	I———I——	······································	<u>.</u>
Provider name	Date last visited	Reason for visit		
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14 DECISION W	, -	CIGIO ZIP	Provider tele	phone number
14. MEDICAL HISTORY QUESTIONS—I	IFETIME	<u> </u>	<del></del>  ()_	
ir or questions "14.8." through "16.c." underline the reco	an I m.	IR complete details		
Is any proposed insured taking any medication(s)?	Yes X No III Yes list merili	ro complete details , Pations and present	as requested in Section	17.)
		anons and present	ed dosages).	
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HAS ANY PROPOSED INSURED EVER BEEN DIAGNO MEDICAL PROFESSION FOR A DISEASE OR DISORD	OSED, TREATED, TESTED POS	ITIVE FOR, OR BE	EN CIVEN MEDION A	
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cancer, a tumor or abnormal growth of any kind? been told he/she had an immune Deilciency Disorder, A				· · · · · · · · · · · · · · · · · · ·
been told he/she had an Immune Deliciency Disorder, A  15. MEDICAL HISTORY QUESTIONS—1	NDS, AIDS related complex (ARC	). Of test requite ladi	Aprilia de la companione de la companion	
15. MEDICAL HISTORY QUESTIONS— L	AST TEN YEARS	y or restriction and	calling exposure to the A	IDS virus?
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any disease or abnormality of the kidneys, urinary bladd	Or produte as !! !	a cumoas, nebantis	and collis?	144778111111-711111111
diabetes or any disease of the thyroid or other gland?	- 7 Production of german systems, and	iuding sugar ör blöd	d in the urine?	***************************************
diabetes or any disease of the thyroid or other gland? arthritis, lupus, physical deformity, any disease of the bo	Den mussler at the			
arthritis, jupus, physical deformity, any disease of the bo treatment or counseling for use of alcohol or alcoholism:	i 168, MUSCIOS OF Joints, or any dis	ease or abnormality	of the eyes, ears or skin	7,
treatment or counseling for drug upo account				
other habit-forming drugs, other than those preceded in	to a physician O	prietamines, najjucij	10genics, narcotics or	
Doss-any proposed losured currently have a sure	2 1 years management			
resume or investigation recommended by a dioctor which	has not not be an in	ou rechitorn \$1 (NOCIOL OL	had any consultation.	
If any proposed insured(s) is less than one year old, give	blith weight: 1 15 L	**************************************	***************************************	
6. MEDICAL HISTORY OUESTIONS LO	CT FUE VEADO	z. was birth premat	ure?	
S ANY PROPOSED INSURED, WITHIN THE LAST FIV	E VEARS			
consulted or been treated or examined the cast riv	E TEARS			
consulted or been treated or examined by any physician had treadmill EKG or other carolovascular test, chest X-ra	or practitioner for any cause not p	previously mentioned	In this application?	
had treadmill EKG or other carolovascular test, chest X-ra had a surgical operation or been under observation or treat	iy, blood or other laboratory test?	National House of December 1		
had a surgical operation or been under observation or treat	any hospital or clinic مع محا	en advised to be		

clinic or been advised to have an operation which was not performed



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AMERICAN NATIONAL INSURANCE COMPANY

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Give full details below of all "Yes" anawars to questions "14.a." through "16.c.")  Question Person  Reason, condition, disease, injury, etc.  Question Person	17. MEDICAL HISTORY EXPLANAT	NATIONAL	4	5937e11
Peason, condition, disease, injury, etc.   Dete	(Give full details below of all 'Yes' answers to crues	TIMALS		
Pleason, condition, disease, injury, etc.    Dete	Question Person			
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Reason, condition, disease, injury etc.  Date  Attending physician  Attending physician address: Number/Street  City  State  18. INSURANCE HISTORY AND NOT-MEDIDAL HAZARDS  Has any proposed insured, in the past five (5) years, applied for life, accident or health insurence or for reinstatement of any such insurance that was ded postponed, cancelled or withdrawn or modified as to plan, emount or rate? Yes No (if **Pés,* give details.)  Has any proposed insured in the last six (6) months, applied for — or is any proposed insured contemptating applying for — other insurance with this, or any or company? Yes No (if **Pés,* state how much and to whom).  Has any proposed insured, in the past live (5) years, made — or is any proposed insured contemptating making — flights as a pilot, student pilot, crew member has any proposed insured, in the past live (5) years, engaged in or does any proposed insured intend to engage in mountain climbing, racing, Sci Has any proposed insured, in the past five (5) years, engaged in or does any proposed insured intend to engage in mountain climbing, racing, Sci Has any proposed insured, in the past five (5) years, engaged in or does any proposed insured intend to engage in mountain climbing, racing, Sci Has any proposed insured, in the past five (5) years, been convicted of a felony? Yes No (if *Yes,* give details including county and state of conviction.)  Is any proposed insured in the last two (2) years resided outside of the United States for more than four (4) weeks?  Yes, complete and submit the Pareign Travel Quastionnaire.)  Has any proposed insured plan to travel outside of the United States for more than four (4) weeks?  Yes, give details, 1  Yes		Attending physician address: Number/Street	City	
Attending physician address: Number/Street City State  18. INSURANCE HISTORY AND NON-MEDIDAL HAZARDS  Has any proposed insured, in the past five (5) years, applied for life, accident or health insurance or for reinstatement of any such insurance that was declared in the last six (6) months, applied for life, accident or health insurance or for reinstatement of any such insurance that was declared in the last six (6) months, applied for life, accident or health insurance or for reinstatement of any such insurance that was declared in the last six (6) months, applied for life, accident or health insurance or for reinstatement of any such insurance with this, or any compeny? Insurance or for reinstatement of any such insurance with this, or any compeny? Insurance or for reinstatement of any such insurance with this, or any compeny? Insurance or for reinstatement of any such insurance with this, or any compeny? Insurance or for reinstatement of any such insurance with this, or any compeny? Insurance or for reinstatement of any such insurance with this, or any compeny? Insurance or for reinstatement of any such insurance with this, or any compeny insured insurance insurance with this, or any compensate any proposed insured, in the past five (5) years, made — or is any proposed insured insurance, in the past five (5) years, engaged in or does any proposed insured insurance in the past five (5) years, been connected of a felony? Insurance and submit insurance or insuran	uestion Person	Ponen de differen	<u>-</u>	. I
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Has any proposed insured, in the past five (5) years, applied for life, accident or health insurance or for reinstatement of any such insurance that was declared and proposed insured or withdrawn or modified as to plan, emount or rate? \( \text{ Yes } \) No \( \text{if "Yes," give details.} \)  Has any proposed insured in the last six (6) months, applied for \( -\text{ or is any proposed insured contemplating applying for \( -\text{ other insurance with this, or any or company? \( -\text{ Yes } \) No \( \text{ if "Yes," state how much and to whom.} \)  Has any proposed insured, in the past five (5) years, made \( -\text{ or is any proposed insured contemplating making \( -\text{ lights as a pilot, student plot, crew member that any proposed insured, in the past five (5) years, engaged in or does any proposed insured insured insurance with this, or any other proposed insured, in the past five (5) years, engaged in or does any proposed insured insured insurance insurance with its appropriate questionnairs.)  Has any proposed insured, in the past five (5) years, been convicted of a felony? \( \text{ Yes } \) No \( \text{ if "Yes," give of etails including county and state of conviction.} \)  Its any proposed insured in the last two (2) years resided outside of the United States for more than four (4) weeks? \( \text{ yes } \) Yes \( \text{ Yes } \) If "Yes, complete and submit the Foreign Travel Questionnairs.}  Has any proposed insured in the last two (2) years resided outside of the United States for more than four (4) weeks? \( \text{ yes } \) Yes \( \text{ Yes } \) If "Yes, give details.)  Has any proposed insured in the last two (5) years? \( \text{ yes } \) Yes \( \text{ Yes } \) If "yes, give details.)  Has any proposed insured in the last two (5) years? \( \text{ yes } \) Yes \( \text{ Yes } \) If "yes, give details.)  Yes \( \text{ yes details.} \)   State: \( \text{ Yes } \) Yes \(  Ye			City ·	State
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ts any proposed insured currently on parole or probation?  Yes  No (If "yes", give details.)  Has any proposed insured in the last two (2) years resided outside of the United States for more than four (4) weeks?	diving bang-oliding bollslaw page ave (a) year	's, engaged in or does any proposed insured intend to appear		
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if 'yes', give details.)   Yes	nave you had a charge or conviction of DWI/DUI or (if 'yes', give details.)	reckless driving in the last five (5) years?	= '	□vo M
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# AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit managers, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency of independent administrator, including medical record retrieval services or pharmaceutical services, acting on AMERICAN NATIONAL INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that American National underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

- (1) such information will be used by AMERICAN NATIONAL INSURANCE COMPANY for underwriting and insurability determinations; (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and

(4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request. This authorization is valid from the date signed for a duration of 24 months, I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of AMERICAN NATIONAL INSURANCE COMPANY, P.O. Box 1720, Galveston, Texas 77553. I may inspect or

## APPLICATION DECLARATIONS AND AGREEMENTS

Each of the undersigned declare for themselves, and all other interested parties, that all of the answers in all pages of this application and any supplements to it are full, and (ii) shall form the basis for and become a part of any policy issued on this application; (2) except as otherwise provided in the conditional receipt with the same serial health of the insured(s); (3) the company may issue a policy different from that specified in this application by listing the difference(s) on the policy data page, and acceptance of such different policy will be a ratification of the changes except that no change in: (i) amount of insurance; (ii) classification; (iii) plan of insurance; or (iv) benefits, will be any proposed insured(s) if not in writing; (4) the company is not bound by any statements made by anyone or any other facts known to anyone concerning the president or a vice president or secretary of the company has the authority to waive any of the company rights or requirements or to waive or alter any of the provisions the president or a vice president or secretary of the company has the authority to walve any of the company rights or requirements or to walve or alter any of the provisions of: (i) this application and any supplement, amendment or modification to this application which has been approved by the Company; or (ii) any policy issued on this application including any supplement, amendment or modification to this application which has been approved by the Company.

#### FRAUD STATEMENT

Any person who knowlngly, and with Intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a

#### MIB ACKNOWLEDGEMENT

I have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau.

#### APPLICATION SIGNATURES

If Conditional Receipt to be attached, I hereby certify that I have read and received the conditional receipt, and agree to its terms. I understand that the company will not permit acceptance of my deposit or detachment of the conditional receipt unless this statement is true (if one given). For Indexed Universal Life:

Lunderstand that I am applying for an indexed universal life policy and that while the value of the policy may be affected by an external index, the policy does

For Variable Universal Life:

I understand that I am applying for a Variable Universal Life Policy. The accumulation value may increase or decrease depending on investment returns and the death benefit may be variable or fixed depending on the death benefit option selected.

2-24 Signed at: City North	State Country USA
Witnessed by: Signature of licensed agent  X X Consul Y LEC	Signature of primary proposed insured (Or guardian, it proposed insured is under age 16)
Print agent's name Leonard New	Signature of additional person(s) proposed for insurance
Agent's state license number 203973	Signature of additional person(s) proposed for insurance  XX
Agent's company personal code D5829	Signature of owner if other than proposed insured  X
ICC0910193	MERICAN NATIONAL INCLUDANCE OF



### AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION One Moody Plaze, Galveston, TX 77550-7999



I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on AMERICAN NATIONAL INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, allments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that American National underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the

#### I understand that:

- (1) such information will be used by AMERICAN NATIONAL INSURANCE COMPANY for underwriting and insurability determinations; (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. Lunderstand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of AMERICAN NATIONAL INSURANCE COMPANY, P.O. Box 1720, Galveston, Texas 77553. I may inspect or copy any information used or disclosed under this authorization, if signed.

2- 11/ 11/	and the street of copy ar
Date  Caroline C. Sher lock  Proposed Insured (Please print)	Signature of Proposed Insured for parent if Proposed Insured is under age 16)
Additional Proposed Insured (Please print)	Birthdate  Signature of Additional Person Proposed for Insurance
	Birthdate
	Personal Representative designated by signature above is hereby authorized to execute this instrument based on; power of attorney, guardian-in-fact, guardian. payee representative, other (Circle one)